DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 0 — 0 1 5

2. STATE: CA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:
a. FFY 2000-01 $ 30,000,000
b. FFY 2001-02 $ 30,000,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Supplement 5 To Attachment 4-19-B, Pages 1-PD 4
Page 58

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
N/A
Supercedes Page 58

10. SUBJECT OF AMENDMENT:
100 Percent Cost-Based Reimbursement to Eligible Clinics Under The Section 1115 Waiver Medicaid Demonstration Project for Los Angeles County

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
The Governor's Office does not wish to review State Plan Amendments

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
GAIL L. MARGOLIS

14. TITLE:
DEPUTY DIRECTOR, MEDICAL CARE SERVICES

15. DATE SUBMITTED:
~~September 29, 2000~~

16. RETURN TO:
Department of Health Services
Attn: SPA Coordinator
714 P Street, Room 1640
Sacramento, CA 95814

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: September 29, 2000

18. DATE APPROVED: January 22, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2000

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Linda Minamoto

22. TITLE:
Associate Regional Administrator
Division of Medicaid

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

State/Territory: California

Citation
42 CFR 447.201
42 CFR 447.302
52 F 28648 (a) (13) (E)
1903 (a) (1) and
(n), 1920, and
1926 of the Act

4.19 (b) In addition to the services specified in paragraphs 4.19 (a), (d), (k), (l) and (m), the Medicaid agency meets the following requirements:

(1) Section 1902 (a) (13) (E) of the Act regarding payment for services furnished by Federally qualified health centers (FQHCs) under section 1905 (a) (2) (C) of the Act. The agency meets the requirements of section 6303 of the State Medicaid Manual (HCFA – Pub. 45 – 6) regarding payment for FQHC services. ATTACHMENT 4. 19-B describes the methods of payment and how the agency determines the reasonable cost of the services (for example, cost-reports, cost or budget reviews, or sample surveys).

(2) Sections 1902 (a) (13) (E) and 1926 of the Act, and 42 CFR Part 447, Subpart D, with respect to payment for all other types of ambulatory services provided by rural health clinics under the plan.

ATTACHMENT 4.19-B describes the methods and standards used for the payment of each of these facility services except for inpatient hospital, nursing facility services and services in intermediate care facilities for the mentally retarded that are described in other attachments.

1902 (a) (10) and
1902 (a) (30) of the Act

SUPPLEMENT 1 to ATTACHMENT 4.19-B describes general methods and standards used for establishing payment for Medicare Part A and B deductible/coinsurance.

SUPPLEMENT 2 to ATTACHMENT 4.19-B describes the methods and standards used for the payment of prescribed drugs dispensed by pharmacists.

SUPPLEMENT 3 to ATTACHMENT 4.19-B describes the standards and methods used to adjust claiming for the federal drug rebate program.

SUPPLEMENT 4 to ATTACHMENT 4.19-B describes the methods and standards used for establishing payment rates for rehabilitative mental health services for seriously disturbed children screened under the early periodic diagnosis, screening and treatment program and served through the Short-Doyle/Medi-Cal program.

SUPPLEMENT 5 to ATTACHMENT 4.19-B describes the methods and standards used for reimbursement at 100 percent of reasonable costs to clinics providing specified Medi-Cal ambulatory services to Medi-Cal beneficiaries and are operated by, or contracted with a county participating in a sub-state Medicaid Demonstration Project authorized under Section 1115 of the Act.

STATE PLAN AMENDMENT
COST-BASED REIMBURSEMENT

A. General Applicability

Notwithstanding any other provision of this State Plan, reimbursement for the types of services described in paragraph B.3, below, that are provided by facilities operated by, or contracting with, a county participating in a sub-state Medicaid Demonstration Project authorized under Section 1115 of the Social Security Act, shall be made as set forth below. This Supplement shall apply only for Medi-Cal services rendered to Medi-Cal beneficiaries on or after July 1, 2000, and only in conjunction with a Medicaid Demonstration Project, as referenced above. The providers or groups of providers who receive cost-based reimbursement under this Supplement will utilize the same cost reporting forms currently used by Federally Qualified Health Centers (FQHCs) in California, except hospital outpatient departments shall utilize the acute care hospital cost report form (HCFA 2552/most current version). This Supplement does not apply to those FQHCs and FQHC look-alikes described in Section 1905(l)(2)(B) of the Act.

B. Cost-Based Reimbursement

1. Methodology

(a) Reimbursement to eligible facilities shall be at 100 percent of reasonable and allowable costs for Medicaid services rendered to Medicaid beneficiaries enrolled in managed care or fee-for-service programs. Reasonable and allowable costs shall be determined in accordance with applicable cost-based reimbursement provisions of the following regulations and publications (except for modifications described in this Supplement or otherwise approved by the Health Care Financing Administration (HCFA)):

(i) The Medicare reimbursement methodology for Rural Health Clinic and FQHC Services specified at 42 C.F.R. § 405.2460 through § 405.2470 (together with applicable definitions in Subpart X of Part 405 to the

extent those definitions are applied by the State in connection with FQHCs in California) and 42 C.F.R. Part 413. In the event of a conflict between the provisions of Part 405 and Part 413, the provisions of Part 405 will govern.

(ii) "The Provider Reimbursement Manual" (HCFA 15-1).

(iii) "Cost Principles for State, Local, and Indian Tribe Governments" (HCFA Circular A-87).

(iv) Rural Health Clinic and FQHC Manual (HCFA Publication 27).

(v) Welfare and Institutions Code, Section 14087.325, Subdivision(e), and any implementing regulations.

(vi) Other applicable federal directives.

(b) The provisions of paragraph B.1(a) and the regulations and publications referenced therein shall be subject to all of the following:

(i) Sections 405.2462(b)(2) through (b)(4), 405.2466(c)(2), and 405.2468(f), shall not be applicable.

(ii) Notwithstanding the provisions of the regulations and publications referenced in paragraph B.1(a), any dollar limit on otherwise allowable costs shall not be applicable.

(iii) Provisions of the regulations and publications referenced in paragraph B.1(a) that are not generally applied by the State to FQHCs in California shall likewise not be applied to eligible facilities subject to this Supplement.

(iv) Clinic visits shall be the basis for apportioning hospital outpatient costs among clinic payers regardless of the provisions of the regulations and publications referenced in paragraph B.1(a).

(v) The time for submitting the annual report specified in 42 C.F.R. § 405.2470(c)(2) shall be five months rather than 90 days.

(c) The methodology for reimbursement adopted by the State to comply with Section 1902(aa) of the Act shall not be applicable to facilities that are paid under this Supplement.

2. Facilities Eligible for Cost-Based Reimbursement

(a) For participating counties as defined in Section A above, county operated hospital outpatient departments (excluding hospital emergency departments), county comprehensive health centers (CHCs), county health centers (excluding clinics that provide predominately public health services), and, to the extent specified in the particular Medicaid Demonstration Project, private clinics that provide health services to the indigent (including General Relief recipients) under a contract with a participating county and that elect to be paid under this Supplement.

(b) Notwithstanding paragraph 2(a), no off-site contracted services shall be subject to cost-based reimbursement. However, this limitation does not apply to reimbursement for services furnished off-site when rendered by a physician or other qualified health professional of the eligible facility's staff. Further, off-site contracted services do not include services ordered by a physician or other qualified health professional at one eligible facility and provided at another eligible facility.

3. Services Eligible for Cost-Based Reimbursement

(a) Subject to paragraph (b), below, the services that are subject to cost-based reimbursement in eligible facilities (as defined in paragraph B.2, above) include only Medi-Cal-covered ambulatory care services rendered to Medi-Cal beneficiaries as described in applicable State law and this State Plan, including, but not limited to, Rural Health Clinic services defined in Section 1861(aa)(1)(A)-(C) of the Social Security Act and preventive primary health services that are required under Section 330 of the Public Health Services Act.

(b) For the purposes of cost-based reimbursement of services that are paid on a per visit basis, a "visit" is defined as a face-to-face encounter between a clinic Medicaid patient and a health care professional. Multiple visits may be billed on the same day of services if a clinic Medicaid patient receives services from more than one health care professional and the nature of the services or the patient diagnoses are unrelated (e.g., a medical and dental visit on the same day could be two visits).

Eligible facilities may bill one visit per group education session such as health education. Eligible facilities under this Supplement will likewise bill one visit per session regardless of the number of participants in the session.

For the first year of the Medicaid Demonstration Project, the county operated facilities may use their current system to claim visits. The State may extend the right to use the current system up to an additional 12 months.

(c) The following services are not subject to cost-based reimbursement under this Supplement nor may a visit be billed for such services:

(i) Medi-Cal specialty mental health services under the State's consolidated Section 1915(b) waiver.

(ii) Medi-Cal Short-Doyle and Medi-Cal alcohol and drug program services paid through the State Department of Alcohol and Drug Programs.

(iii) Adult Day Health Care services.